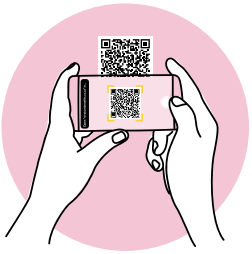
| 2022 |

Stratum Benefits

CORPORATE ACCESS PLUS

It's our **booster option** that covers specific medical procedures and events that an employee's medical aid plan excludes from cover, as well as provides cover for the **most likely** medical expense shortfalls that employees may experience on doctors' and specialists' private fees.

One policy covers you, your spouse and all the dependants registered on both your and your spouse's medical aid plans. Ask your employer if your spouse and dependants may also join.



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KEY BENEFITS SUBJECT TO AN OVERALL POLICY LIMIT (OPL)

*An **OPL** of **R 177 835 per policy per year** applies to the following benefits regardless of whether you're covered as an individual or a family. This means that all approved claim amounts will get deducted off the **OPL**.*

ACCESS COVER

Need one or more of the below listed medical procedures, but your medical aid plan excludes it from cover?

We've got the key because the cost of your admission to a hospital or day clinic, and all your related healthcare providers' accounts will be covered by us limited to the rand amounts as shown below:

MEDICAL PROCEDURE/EVENT NOT COVERED BY YOUR MEDICAL AID	ACCESS COVER PROVIDES
Arthroscopic surgery	R 50 000
Back or neck surgery	R 50 000
Bunion surgery	R 14 000
Cochlear implant, auditory brain implant and internal nerve stimulator surgery (including the procedure, device, processor and hearing aids)	R 80 000
Dental procedures for impacted teeth for children **younger** than **18**	R 14 000
Dental procedures for reconstructive surgery required due to an accidental event	R 80 000
Endoscopic procedures	R 5 000
Functional nasal surgery	R 23 000
Joint replacement surgery (including non-PMB joint replacements and internal prosthetic devices)	R 50 000
Knee or shoulder surgery	R 25 000
MRI or CT scan required due to an accidental event	R 10 000
Non-cancerous breast conditions (including breast reconstruction of a breast not affected by cancer)	R 20 000
Oesophageal reflux and hiatus hernia surgery	R 55 000
Removal of varicose veins	R 20 000
Skin disorders (including benign growths or lipomas)	R 20 000

Benefits are available to every person on the policy, but the benefit limits are shared subject to the OPL.

YOUR NEXT STEP

- When your doctor or specialist lets you know that you need any of the listed medical procedures or treatments, you must get cost estimates from your preferred hospital or day clinic, and all the related healthcare providers.
- We'll issue a guarantee of payment as an undertaking to pay your doctor, specialist, hospital or day clinic directly after your claim is approved.

GAP COVER

Going into hospital to have your appendix removed, or having a biopsy done in the doctor's rooms?

Gap Cover kicks in when your doctor or specialist charges more than the amount your medical aid pays for **in-** and **out-of-hospital medical procedures**, as long as it's paid from a **hospital benefit**.

We add an **additional 500%** cover on top of what your medical aid plan gives to cover shortfalls for:

- medical procedures performed by your doctor and specialist;
- basic radiology, like black and white x-rays;
- specialised radiology, like MRI and CT scans;
- consumable items, like surgical gloves;
- dental procedures, like wisdom teeth extractions, limited to **R 6 000 per policy per year**;
- dental procedures due to accidents or cancer treatment, limited to **R 8 000 per policy per year**;
- medication administered during your medical event;
- pathology;
- physiotherapy; and
- Prescribed Minimum Benefit (PMB) medical procedures.

*Remember... if your medical aid makes payment from your **medical savings account**, our **Gap Cover Benefit** won't apply.*

CASUALTY COVER

ACCIDENT COVER

*For the **whole family***

For **immediate** medical treatment due to an **accident** you can go to your nearest **medical facility**.

ACCIDENTS are unexpected incidents that cause physical injury due to physical impact with someone or something.
IMMEDIATE means within 24-hours from the time of the incident.

What do we cover? Everything related to your casualty event, like:

- facility and doctors' consultation fees;
- co-payments and deductibles related to your casualty event that you pay from your **own pocket**, or that your medical aid pays from your **medical savings account**;
- basic radiology, specialised radiology and pathology;
- medication administered during your casualty event; and
- external medical items that's given to you at the medical facility, like a neck brace.

Need a follow-up visit to a medical facility after an accidental event to have stitches or a cast removed? We'll refund that too.

ILLNESS COVER

Only for children who are 10 years or younger

If your child who's **10 years** or **younger** gets sick after-hours, we'll cover the cost of a visit to a **casualty facility** and all the healthcare providers' accounts related to the visit.

*WHEN IS AFTER-HOURS? **Mondays** to **Fridays** between **18:00pm** and **07:00am** and all-day **Saturdays**, **Sundays** and **public holidays**.*

We'll refund the amount that you pay from your **own pocket**, or that your medical aid pays from your **medical savings account**.

Casualty Cover is limited to **R 2 000 per policy per year**.

BENEFIT NOT SUBJECT TO AN OVERALL POLICY LIMIT (OPL)

*The following benefit isn't subject to the **OPL** because we give this benefit to you **over and above** the benefits that form part of the **OPL**.*

PAYOUT BENEFIT

ACCIDENTAL DISABILITY AND DEATH

You and your spouse are covered for a benefit amount of **R 5 000 per person** if either one of you becomes totally and permanently disabled, or passes away due to an accident.

Limited to **1 event per person per year**.

ACCESS COVER 10 MONTH LIMITED PAYOUT BENEFIT

If you claim from our ACCESS COVER within the first 10 months of cover for a medical event related to:

- arthroscopic surgery;
- back or neck surgery;
- bunion surgery;
- cochlear implant, auditory brain implant and internal nerve stimulator surgery (including the procedure, device, processor and hearing aids);
- dental procedures for impacted teeth for children **younger** than **18**;
- endoscopic procedures;
- functional nasal surgery;
- joint replacement surgery (including non-PMB joint replacements and internal prosthetic devices);
- knee or shoulder surgery;
- non-cancerous breast conditions (including breast reconstruction of a breast not affected by cancer);
- oesophageal reflux and hiatus hernia surgery;
- removal of varicose veins; or
- skin disorders (including benign growths or lipomas),

we'll cover between 20% and 100% of the **approved claim amount** subject to the benefit limits, and subject to the quote accepted by your employer.

If your medical event is related to a medical condition that you received advice or treatment for within **12 months** before the start date of your policy, your claim will be subject to a **Pre-Existing Condition Waiting Period**.

Accidental events don't form part of the **10 Month Limited Payout Benefit** and aren't subject to any waiting periods.

GAP COVER 10 MONTH LIMITED PAYOUT BENEFIT

If you claim from our GAP COVER in the first 10 months of cover for a medical event related to:

- adenoidectomy;
- myringotomy/grommets;
- cataract removal;
- hernia repairs;
- MRI, CT and PET scans;
- pregnancy and childbirth;
- tonsillectomy;
- cardiovascular procedures;
- dentistry;
- joint replacements;
- nasal and sinus surgery;
- spinal procedures;
- scopes (including medical events where a scope is used); or
- hysterectomy (full cover applies if required due to cancer when diagnosed after the **General Waiting Period**),

we'll cover between 20% and 100% of the **approved claim amount** subject to benefit limits, where applicable, and subject to the quote accepted by your employer.

If your medical event is related to a medical condition that you received advice or treatment for within **12 months** before the start date of your policy, your claim will be subject to a **Pre-Existing Condition Waiting Period**.

Accidental events don't form part of the **10 Month Limited Payout Benefit** and aren't subject to any waiting periods.

WAITING PERIODS

Waiting periods may apply from the start date of your policy and from each insured person's cover start date, subject to the quote accepted by your employer.

3 MONTH GENERAL WAITING PERIOD

We don't cover you during this period unless you claim for accidental events that occur after your cover start date.

12 MONTH PRE-EXISTING CONDITION WAITING PERIOD

We don't cover you during this period for investigations, medical procedures, surgeries or treatments related to any illness or medical condition that was diagnosed, or that you received advice or treatment for within **12 months** before your policy's start date.

LIFESTYLE BENEFIT

Our **Lifestyle Benefit** is complimentary and doesn't cost you a cent.

EXTRA HIGH SCHOOL LEARNING SUPPORT

Based on the **CAPS curriculum**, your **Gr.8** to **Gr.12** high school child gets instant access to content that'll help them study, improve their knowledge and boost their marks. Check out our website to see what else this **Lifestyle Benefit** offers.

*Visit our website at **www.stratumbenefits.co.za** to read more about this **LIFESTYLE BENEFIT** and how to register.*

Our Gap Cover policy isn't a medical aid, doesn't provide similar cover as that of a medical aid, and can't be substituted for medical aid membership.

BENEFIT EXCLUSIONS

KEY BENEFITS SUBJECT TO THE OVERALL POLICY LIMIT (OPL)

1. ACCESS COVER

Need a medical procedure that your medical aid plan excludes from cover? We'll cover all your related healthcare and service providers' accounts if your medical procedure is listed as one of the medical events that our benefit covers.

WHAT OUR BENEFIT DOESN'T COVER

We don't cover coded lines on your healthcare or service providers' accounts:

1.1 if your medical aid paid it as an exception to the rule.

1.2 if your medical aid processed it against your self-payment gap. *(A self-payment gap applies when you've used the funds in your medical savings account and pay your day-to-day medical expenses from your own pocket, up to a specific amount.)*

1.3 if it's for medical procedures or treatments that your medical aid plan doesn't exclude from cover.

1.4 if it's for medical procedures or treatments that your medical aid plan excludes, but it's not the medical procedures or treatments that we cover.

1.5 at a higher benefit percentage than the percentage applicable to the employer group if you claim in the first 10 months of cover from a benefit limit provided by your policy, for medical events related to:

- 1.5.1 arthroscopic surgery;
- 1.5.2 back or neck surgery;
- 1.5.3 bunion surgery;
- 1.5.4 cochlear implant, auditory brain implant and internal nerve stimulator surgery (including the procedure, device, processor and hearing aids);
- 1.5.5 dental procedures for impacted teeth for children younger than 18;
- 1.5.6 endoscopic procedures;
- 1.5.7 functional nasal surgery;
- 1.5.8 joint replacement surgery (including non-PMB joint replacements and internal prosthetic devices);
- 1.5.9 knee or shoulder surgery;
- 1.5.10 non-cancerous breast conditions (including breast reconstruction of a breast not affected by cancer);
- 1.5.11 oesophageal reflux and hiatus hernia surgery;
- 1.5.12 removal of varicose veins; or
- 1.5.13 skin disorders (including benign growths or lipomas).

2. GAP COVER

Our benefit kicks in when your doctor or specialist charges more than the amount your medical aid pays for in- and out-of-hospital medical procedures, as long as the payment your medical aid makes isn't from your medical savings account.

We add an additional **500%** cover on top of what your medical aid plan gives to cover shortfalls.

WHAT OUR BENEFIT DOESN'T COVER

We don't cover coded lines on your healthcare or service providers' accounts:

2.1 if your medical aid paid it as an exception to the rule.

2.2 if your medical aid didn't partly pay it from a hospital benefit.

2.3 if your medical aid fully paid it from a hospital benefit, as there'll be no claimable shortfall.

2.4 if your medical aid partly or fully paid it from your medical savings account.

2.5 if your medical aid processed it against your self-payment gap. *(A self-payment gap applies when you've used the funds in your medical savings account, after which you have to pay your day-to-day medical expenses from your own pocket up to a specific amount.)*

2.6 if it's for upfront fees or deposits that your healthcare providers ask you to pay to them directly.

2.7 if it's for out-patient consultation fees, unless a medical procedure was performed at the same time.

2.8 if it's for pre-natal (pre-birth) consultations, including all ancillary procedures or investigations performed during, or following your consultation.

2.9 if it's for hospital accounts, unless you're claiming for consumable items or medication that your medical aid partly paid from a hospital benefit.

2.10 if it's for allied healthcare providers, unless your policy provides a benefit that covers it. *(Allied healthcare providers are healthcare professionals associated with your medical event who aren't doctors or specialists. We only cover the following allied healthcare providers:*

- *2.10.1 clinical perfusionists;*
- *2.10.2 dental hygienists;*
- *2.10.3 midwives;*
- *2.10.4 nurses; and*
- *2.10.5 physiotherapists.)*

2.11 if your medical aid didn't partly pay it because a benefit limit provided by your medical aid plan's been reached.

2.12 at a higher benefit percentage than the percentage applicable to the employer group if you claim in the first 10 months of cover from a benefit limit provided by your policy, for medical events related to:

- 2.12.1 adenoidectomy;
- 2.12.2 tonsillectomy;
- 2.12.3 myringotomy/grommets;
- 2.12.4 cardiovascular procedures;
- 2.12.5 cataract removal;
- 2.12.6 dentistry;
- 2.12.7 hernia repairs;
- 2.12.8 hysterectomy (unless it's for cancer that's diagnosed after a General Waiting Period);
- 2.12.9 joint replacements;
- 2.12.10 MRI, CT and PET scans;
- 2.12.11 nasal and sinus surgery;
- 2.12.12 pregnancy and childbirth;
- 2.12.13 spinal procedures; or
- 2.12.14 scopes (including medical events where a scope is used).

3. CASUALTY COVER

You're covered at the nearest registered medical facility when you need immediate medical treatment due to an accident.

Children who are 10 years or younger are also covered for after-hours treatment due to illness at a registered casualty facility.

WHAT OUR BENEFIT DOESN'T COVER

We don't cover coded lines on your healthcare or service providers' accounts:

3.1 if it's not related to an accident.
3.2 if it's not related to illness of your child dependant who's 10 years or younger.
3.3 that are related to an accident, but medical treatment wasn't provided within 24-hours from the time of the incident.
3.4 if it's for medication that wasn't administered during your casualty event, during a follow-up visit to a registered medical facility after an accidental event, medication that you take home, or that's prescribed to collect at a pharmacy.
3.5 if it's for external medical items that you didn't receive at the registered medical facility during your initial casualty visit.
3.6 if it's for follow-up visits that aren't related to accidental events.
3.7 if it's for follow-up visits at a registered medical facility that are related to an accident, but follow-up visits occurred after a hospital admission. *(When you're admitted to hospital after being treated at a registered medical facility, the hospital admission will be a new event, and return visits for follow-up treatment won't be assessed under Casualty Cover.)*
3.8 if it's for medical treatment due to illness provided to your child who's 10 years or younger, but treatment wasn't provided at a registered casualty facility.
3.9 if it's for medical treatment due to illness at a registered casualty facility for your child who's 10 years or younger, but your child didn't receive after-hours treatment. *(After-hours is Mondays to Fridays between 18:00pm and 07:00am and all-day Saturdays, Sundays and public holidays.)*
3.10 if it's for medical treatment due to illness provided to your child who's older than 10 years.
3.11 that you didn't pay from your own pocket, or that your medical aid didn't pay from your medical savings account.

BENEFIT NOT SUBJECT TO THE OVERALL POLICY LIMIT (OPL)

PAYOUT BENEFIT

4. ACCIDENTAL DISABILITY AND DEATH

We pay a benefit amount in the event of total and permanent disability or death due to an accident.

WHAT OUR BENEFIT DOESN'T COVER

We don't cover instances:

4.1 if total and permanent disability or death isn't due to an accident.
4.2 if it exceeds one claimable event per qualifying person in a benefit year.
4.3 if a death certificate or proof of disability isn't provided, where applicable.

GENERAL EXCLUSIONS

We don't cover healthcare or service providers' accounts related to any medical procedure, treatment, hospitalisation, illness, disease, loss, damage, death, bodily injury or liability for:

1. events that occurred when you weren't an insured person.
2. events that occur during a policy waiting period, unless it's for accidental events.
3. events where your policy's overall policy limit or a benefit limit has been reached.
4. amounts that exceed the additional 500% cover that your policy provides.
5. events where your policy doesn't provide the right benefit to claim from.
6. events that could qualify for more than one benefit provided by your policy, but because the initial medical event's been assessed and registered under a specific key benefit, any related treatment as a result of the initial medical event, or events that follow the initial medical event won't be considered under another benefit.
7. claims that we've assessed as Prescribed Minimum Benefit (PMB) medical procedures that your medical aid reviews afterwards, and partly or fully pays according to the agreed payment arrangement your medical aid has with your healthcare or service provider.
8. events where you didn't obtain pre-authorisation from your medical aid, or where you didn't follow your medical aid's rules.
9. maxillofacial surgery and related medical conditions or procedures, unless it's related to accidental injury or cancer.
10. prescription medication that you collect at a pharmacy or medication that's given to you to take home.
11. external prostheses, like artificial limbs.
12. external medical items, like crutches and birthing pools.
13. mechanical or computerised devices, like ventilators, unless your policy has a benefit that covers it.
14. co-payments related to robotic surgery.
15. artificial insemination, infertility treatment, procedures or contraceptives, unless you're claiming for tubal ligation, a vasectomy, or a contraceptive device implant if your policy has a benefit that covers it.
16. obesity and bariatric surgery.
17. reconstructive cosmetic surgery.
18. a breast reconstruction if it's not the first breast reconstruction in your lifetime. *(A breast reconstruction can be an implant or removal of a breast implant.)*
19. home nursing, admission to a step-down or sub-acute facility, like a frail care centre, rehabilitation facility and hospice.
20. mood disorders, emotional and psychological illnesses.
21. sleeping disorders.
22. stem cell harvesting or treatment.
23. costs related to medical reports.
24. claims where we've negotiated discounts with your healthcare and service providers and paid them in full.
25. claims that are resubmitted due to your healthcare or service provider increasing their fees which results in additional shortfalls, but your claim has already been finalised by us.
26. information that you didn't tell us about that can affect the assessment or acceptance of risk.
27. events that are covered by more than one Gap Cover insurer.
28. routine physical, diagnostic procedures or examinations that you go for as a standard and not because you require medical attention, unless your policy has a benefit that covers it.
29. transport charges and healthcare services that's provided to you while being transported in an emergency vehicle, vessel, or aircraft.
30. deliberate criminal or fraudulent acts, or any illegal activity conducted by you or a member of your household which directly, or indirectly results in loss, damage, or injury.
31. attempted suicide or intentional self-injury.
32. deliberate exposure to exceptional danger, unless you attempt to save a human life.
33. events where the use of drugs or alcohol is involved.
34. riots, wars, political acts, public disorder, terrorism, civil commotions, labour disturbances, strikes, lock-out or any attempt to such acts.
35. active military, police or police reservist activities while you are on active duty.
36. nuclear weapons material, ionising radiations or contamination by radioactivity from any nuclear fuel, nuclear waste or from the combustion of nuclear fuel that includes any self-sustaining process of nuclear fission.
37. events that are covered by legislation, like contractual liability and consequential loss.